AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION 4/11/03

PATIENT NAME (Current and Previous)_____

DOB:_____ **SSN**_____**Phone (H)**_____ **Phone (W)**_____

ADDRESS:_____

Provider — Who has the information? ☐ Hospital ☐ Clinic ☐ Other
Name and Address:_____
Ph:_____ FAX:_____

Requestor — Who needs the information? ☐ Patient ☐ Hospital ☐ Clinic ☐ Other
Name and Address_____
Ph:_____ FAX:_____

Information Required

☐ Consultation Reports	☐ Lab Data ☐
☐ Discharge Summaries	☐ Operative/Outpatient Reports
☐ EKG Reports	☐ Clinic Visit Notes
☐ ER Reports	☐ Pathology Reports
☐ History & Physical	☐ X-Ray Films / X-Ray Reports
☐ Immunization Record	☐ Other_____

Medical Condition/Injury And Time Period — Dates and Description of Condition/Injury:_____

Restrictions (optional) — List Restrictions regarding information to be released:_____
All records pertaining to mental Health, chemical dependence, And/or AIDS-related illness will be released unless otherwise indicated here.

Purpose of Release

☐ Continued Care	☐ Consult/ Second Opinion/ Personal
☐ Education/Research	☐ Insurance Claims Process or Work Comp
☐ Moving Out of Town	☐ Selected New Physician
☐ Legal	☐ Other_____

REVOCATION: I understand that I may revoke this consent at any time and that the consent will automatically expire 12 months from the date of my signature.

I do not authorize further release to any third party. I understand that once information is released under this authorization, Parkview Medical Clinic and their employees and physician(s) cannot prevent the redisclosure of that information.

AUTHORIZATION: I authorize the above provider to release the information marked above to the recipient.

_____ (Signature of Patient/Guardian)

_____ (Relationship to Patient if Signed by Guardian)

_____ (Date of Patient's Signature)

_____ (Reason Patient Unable to Sign)

Records Copied:_____ (Date) By Whom_____

Medical record copies will be: Mailed_____ **Picked Up**_____